b

INSTITUTE OF SOUTHERN AFRICAN STUDIES

THE NATIONAL UNIVERSITY OF LESOTHO

RESEARCH REPORT NO. 14

MALE ATTITUDES TO AND RESPONSIBILITIES IN FAMILY PLANNING IN LESOTHO.

D. E.T. Clarke

Department of Sociology/Social Anthropology
Research Associate
Institute of Southern African Studies
National University of Lesotho .

DECEMBER, 1984.

Institute of Southern African Studies
National University of Lesotho
P.O. Roma 180
LESOTHO.

MALE ATTITUDES TO AND RESPONSIBILITIES IN FAMILY PLANNING IN LESOTHO

Dr. E.T. Clarke

Department of Sociology/Social Anthropology
Research Associate,
Institute of southern African Studies
National University of Lesotho

DECEMBER, 1984.

TABLE OF CONTENTS

LIST OF TABLES

ACKNOWLEDGEMENTS

I would like to thank the staff of the Institute of Southern African Studies for their financial and moral support throughout the period of this survey, as well as the research students who assisted with the fieldwork.

My most sincere thanks is extended to Mr. Tom Lynn and Janet Tomkins, whose editorial guidance made this document readable.

Thanks are also due to the Lesotho Planned Parenthood Association, and to the International Planned Parenthood Association for making the project possible, and for being patient and understanding during the final preparation of the research report.

1. ABSTRACT

In Lesotho, as in other countries, a strong female bias has persisted in formal family planning programmes, while the important influence of males in the acceptance and use of family planning methods has largely been ignored. As the Lesotho Government attempts to manage population growth, even while respecting traditional religious and cultural values, the importance of facilitating the development of favourable male attitudes towards family planning is becoming increasingly apparent. The objective of this research was to determine contemporary male attitudes to and responsibilities in family planning in Lesotho. 658 Basotho males between the ages of 19 and 60 were interviewed for the purpose of the study. The sample included respondents in all ten districts of Lesotho, representing a broad range of occupations and educational levels. This paper details the findings of the survey, and provides a series of corresponding recommendations to the Lesotho Planned Parenthood Association, who commissioned the study.

2. INTRODUCTION

The female bias in formal family planning programmes began with the first birth control clinics, which were established in Great Britain by Marie Stopes and in the United States by Margaret Sanger. These pioneers were concerned with the suffering of women who had too many children close together, so it was natural for them to champion the role of women in family planning.

At the present time, we continue to use family planning programmes tailored to meet the needs of women rather than men. Educational programmes frequently focus on women only, instead of involving couples and families, and therefore do not facilitate the development of favourable male attitudes towards family planning. The failure of family planning administrators to focus attention on the influence of males in family planning has persisted despite the fact that without the consent of the man, a wife, fiance, or girlfriend may be prohibited from attending family planning clinics, even if she desires to do so (Gatweh 1978).

The Lesotho Government, while respecting traditional religious and cultural values, clearly has a responsibility to manage population growth for development purposes. Working towards this objective, the Government has supported family planning through the Ministry of Health and other non-government health authorities, such as mission hospitals and the Lesotho Planned Parenthood Association (LPPA). Although the government and LPPA have provided services through which couples can obtain contraceptives and plan their families, programme implementation in Lesotho has been difficult, because of certain Basotho cultural barriers, including the family structure, religious beliefs, and the need to have a male heir.

The traditional family planning practice in Lesotho is for couples to practice withdrawal: however, there is often also a complete abstinence from sexual relations for two years or more after the birth of a child, sometimes until the child begins to walk. In the past, this contributed to the traditional practice of polygamy, which is now almost non-existent.

The availability of contraceptives, and the growing economic independence of women have changed the situation dramatically. Men, particularly those in the traditional society, feel that their position of dominance is being threatened. It is understandable, however, that it is often the husband, anxious to maintain control over his wife and family, who is reluctant to accept government family planning policies.

A factor which traditionally inhibited the acceptance of family planning was the mortality rate among young children. In the past, parents expected to lose half of their children to childhood diseases. It was therefore necessary to have as many children as possible, to ensure that some of the offspring survived to adulthood. As a result of advanced medical knowledge, better hygiene practices, and child care, however, many childhood diseases have been eradicated, and many more children survive to adulthood.

The increasing number of better-educated couples has also had an impact on the development of family planning practices in many Third World societies. Such couples delay childbearing in order to finish their education or to pursue a profession. They usually assume full responsibility for their children's education and physical well-being, instead of relying on support from the extended family. Moreover, the husbands are willing to adopt a more equal relationship with their wives, accepting them as partners rather than primarily as childbearers, and recognizing the importance of their social and financial contributions to the family.

In the light of this traditional yet socially changing background, we investigated contemporary male attitudes towards family planning in Lesotho.

3. METHODOLOGY

Source of Data

The primary source of data was a random sample of 658 male Basotho from the ten districts of Lesotho. The respondents were required to satisfy the following conditions in order to qualify for inclusion in the study: (1) they had to be male; (2) they had to be Basotho; and (3) they had to be between the ages of 19 and 60 years.

Selection of Sample

The sample was drawn from the following status groups:

(1) Miners
(2) Unemployed persons
(3) Students
(4) Civil servants
(5) Members of the National Assembly

(1) Miners. In Lesotho there are two main recruitment agencies for migrant workers--TEBA and AGROL. Our original intention was to select our sample from both agencies. We subsequently discovered that TEBA was the bigger organization, with offices in eight of the districts: Butha Buthe, Leribe, Berea, Maseru,

Mafeteng, Mohales Hoek, Quthing and Qacha's Nek. Miners from Mokhotlong and Thaba Tseka are recruited in Leribe and Maseru offices respectively. An approach was made to the Director of TEBA in Lesotho, who gave us permission to visit the district offices. We received considerable cooperation from the local/ district managers during our study.

(2) Unemployed persons. Uemployed persons were randomly selected in the district towns. No attempt was made to vist rural villages, because most able-bodied men visit the towns frequently in search of employment.

(3) Students. Married and unmarried third and fourth-year students at the National University of Lesotho (NUL) were randomly selected.

(4) Civil servants. Civil servants were selected from four Lesotho Government ministries: Agriculture, Education, Health, and Statistics. These ministries were selected primarily because they have the largest male populations.

(5) Members of the National Assembly. Members of the National Assembly were selected and interviewed either at their offices or at the National Assembly Building.

Fieldwork

The research project on 'Male Attitudes to and Responsibilities in Family Planning in Lesotho' started in May 1983, after the original research design had been revised. The objective of the first working proposal had been to interview miners in Maseru, and to hypothesize the attitudes of Basotho males towards family planning on the basis of these findings. By the terms of the new working proposal, it became the objective of the principal researcher to interview a representative number of Basotho males from various occupations, drawn from all the districts of Lesotho. Each individual in the sample was interviewed on the basis of an interview schedule, a copy of which is included in this report (Appendix 1). In some cases, individuals did not state their response to specific questions. This explains the fact that the number of respondents reported in the tables does not always total 658.

The major constraints in our study were lack of time and insufficient funding. The research budget was inadequately drawn up; as a result, we wasted a lot of time in a futile pursuit of funds from various agencies. Apart from these difficulties, the fieldwork was successfully completed. We intended interviewing more MPs and ministers of the church, but were unable to do so, because the research assistants had to recommence university, and furthermore, we did not have enough money to hire other fieldworkers.

4. CHARACTERISTICS OF RESPONDENTS

Our sample was composed of 658 respondents. The fieldworkers attempted to interview an equal number of males from each district, but time, financial constraints, and accessibility

to some districts were major setbacks. As a result, more respondents were interviewed in Maseru (18.3%) as compared to Thaba Tseka, where only 4.5% were selected. The following table indicates the geographical distribution of the respondents.

TABLE 1: RESPONDENTS BY DISTRICT

District	No. of Respondents	Adjusted Percentage
Maseru	121	18.0
Mafeteng	90	13.0
Leribe	83	12.0
TY (Berea)	78	12.0
Butha Buthe	39	5.9
Mohales Hoek	66	10.0
Quthing	40	6.1
Quacha's Nek	59	9.0
Mokhotlong	52	8.0
Thaba Tseka	30	4.5
	658	100.0

Of the 658 interviewed, 30.6% were unmarried, 68.3% married, 0.9% divorced, and 0.2% widowed. The mean age of respondents was 31 years. The various adult age categories were represented approximately equally, except for age range 20-34.

TABLE 2: AGE RANGE OF RESPONDENTS

Age Range	No. of Respondents	Adjusted Percentage
15-19	33	5.0
20-24	198	30.1
25-29	113	17.2
30-34	104	15.8
35-39	68	10.3
40-44	40	6.1
45-49	35	5.3
50 and over	40	6.1
Don't know	27	4.1
	658	100.0

32.1% of the respondents were miners, 19.6% were civil servants, and 40.1% were unemployed/job-seeking. Further, 22.3% of the respondents had no formal education, 33.4% had not completed their primary education, and 26.3% had post-secondary education (including diplomas, degrees, etc.)

TABLE 3: EDUCATIONAL STATUS OF RESPONDENTS

	No. of Respondents	Adjusted Percentage
Primary incomplete	217	35.0
Primary graduate	52	8.4
Secondary incomplete	29	4.6
Post-secondary	64	10.2
Other (degree, diploma, etc.)	107	17.2
Not attended school	153	24.6
	622	100.0

Lesotho is predominantly a Catholic country. This was reflected in our sample, of which 44.5% were members of the Catholic church, and 26.1% were members of the Lesotho Evangelical Church (LEC). Only 8.5% had no stated religious affiliation.

TABLE 4: RELIGION OF RESPONDENTS

	No. of Respondents	Adjusted Percentage
Catholic	293	44.5
Anglican	76	11.6
LEC	172	26.1
Methodist	17	2.6
Seventh Day Adventist	2	0.3
Baptist	8	1.2
Other	34	5.2
No Religion	56	8.5
	658	100.0

5. FAMILY PLANNING

Awareness of Family Planning

Our first level of inquiry was concerned with what percentage of respondents had heard of family planning. 66.7% reported having heard of family planning.

TABLE 5: HAVE YOU HEARD OF FAMILY PLANNING?

	No. of Respondents	Adjusted Percentage
Yes	439	66.7
No	215	32.7
Don't know	4	0.6
	658	100.0

It is interesting to note that in the Lesotho Distance Teaching Centre study (1978), only 13% of the sample, which included both males and females, had heard of family planning. Our findings, then, suggest that a dramatic increase has occurred in the general awareness of family planning among the Basotho. This is even more remarkable considering the fact that our sample comprised males only.

We also inquired as to the medium through which family planning awareness was obtained. Respondents had heard of family planning from several sources, including conversation, friends, and the radio.

TABLE 6: WHERE DID YOU FIRST HEAR OF FAMILY PLANNING?

	No. of Respondents	Adjusted Percentage
Never heard of family planning	215	32.7
Radio	158	24.0
Books	6	0.9
School	35	5.3
At home (parents)	61	9.3
Mines	11	1.7
Hospital/clinic	34	5.1

(cont. next page)

TABLE 6: WHERE DID YOU FIRST HEAR OF FAMILY PLANNING? (cont.)

	No. of Respondents	Adjusted Percentage
Conversation/friend	115	17.5
Don't remember	23	3.5
	658	100.0

24% of the respondents first heard of family planning on the radio. The radio, as noted in Table 6, appears to be the most effective medium through which knowledge of family planning can be disseminated. About 70% of the population in Lesotho have, or have access to, a radio (personal communication from Lesotho Broadcasting Corporation staff). Mokhotlong and Qacha's Nek are the only two districts where radio communication is difficult.

Before commencing our study, we were informed by the Employment Bureau of Africa (TEBA) that the mining authority held family planning discussions as a part of their health education programme for miners. However, only 14.8% of the respondents had heard about family planning while on contract labour. Data obtained from the Information, Education and Communication Officer (IECO) of the LFPA revealed that there is a health education officer working in one of the TEBA mines who gives talks on family planning. This is further supported by the number of letters received by the IECO from miners, requesting further information about male and female contraceptives (see Appendix 2)

In Basotho homes, discussions on family planning and other sex-related topics are rarely held between spouses, and occur even less between parents and children; the subject is a cultural taboo. This was reflected in the high number of respondents -- 631 or 96% -- who reported never having discussed family planning with their parents.

The respondents appeared to have heard more about family planning than about the family planning associations. 60% had never heard of the Lesotho Family Planning Association, or its successor, the Lesotho Planned Parenthood Association.

Although 66.7% of the sample had heard about family planning, none of the respondents had visited a family planning clinic.

Religion and Family Planning

It is generally believed by family planning educators that members of the Roman Catholic church disapprove of family planning. However, only 9% of our sample, irrespective of religious affiliation, said that their minister of religion disapproved of family planning; however, 76.4% didn't know

the views of their minister. Of the 9% who stated that their minister of religion disapproved of family planning, only 6.2% reported that it was 'against church teaching'.

When respondents were asked whether their religious beliefs affected their attitudes to contraception, 15% said that they did, while 65% claimed that their religious beliefs had no effect.

A breakdown of data suggests that there may be some variation in attitudes according to religious affiliation. When asked about their general attitude to family planning, 45.4% of Catholics, 52.6% of Anglicans, and 52.6% of members of the Lesotho Evangelical Church (LEC) considered family planning a good idea. On the other hand, 15.4% of Catholics, 11.8% of Anglicans, and 11% of members of the LEC were against or hated family planning.

C.H. Motsone, in a study on Family Planning Attitudes in Maseru reported that of the 52% of her sample who were Catholic, 40% were using modern contraceptive methods. Further, she noted that Roman Catholics constituted the highest number of family planning acceptors. Although it is generally believed that church authorities disapprove of modern family planning, our study has confirmed that many church members use family planning for their own convenience. They find modern methods such as the pill, intrauterine device, injectables, and foaming tablets more useful in regulating their family size than the methods recommended by the church, which include the rhythm method and the Billings method. In summary, church affiliation in contemporary Lesotho does not appear to have a significant influence on family planning practices.

Cost and Time of Family Planning Service

Providing family planning services on a national basis is very expensive. In many countries, a nominal fee is charged by the government for using the family planning service. To determine male opinion on whether a charge should be levied for the use of family planning services, we asked our respondents how much they would pay for family planning services per clinic visit.

Many of the respondents (48.1%) didn't know how much they would be willing to pay for family planning services; 15% felt that the service should be free. Of those who were willing to pay, 10.2% preferred to pay between M2.00 and M5.00.

Table 7 indicates the variation among respondents in the amount they were prepared to pay for family planning services.

TABLE 7: NOMINAL FEES RESPONDENTS WERE PREPARED TO PAY FOR FAMILY PLANNING SERVICES

	No. of Respondents	Adjusted Percentage
Less than M2.00	81	12.4
Between M2.00 and M5.00	67	10.2
Over M5.00	24	3.7
Free-of-charge	102	15.5
It doesn't matter	65	10.6
Don't know	314	48.1
	658	100.0

The respondents were next asked to consider how much time they would be willing to spend on a visit to a clinic. 55% were unable to decide how much time they would be prepared to spend. However, 14.3% said that they would be willing to spend more than one hour, while 12.4% said that they would not spend more than 30 minutes.

6. FAMILY SIZE

In this section of the interview, the respondents were first asked how many children they had. 315 (58.3%) had one to four children, and 166 respondents had no children. The mean number of children respondents had was two. We had expected more children per family, because of the traditional/religious nature of the Basotho society. In fact, only 57 (10.6%) had five or more children (see Table 8).

While traditionally it was common for a man to have several wives, it is rare for a man to have more than one wife in contemporary Lesotho. Only five respondents had two wives.

We asked respondents what they thought would be an ideal number of children for a couple today. 27% of the respondents said four children. The mean number of children was 4.1 (see Table 9).

TABLE 8: NO. OF CHILDREN RESPONDENTS HAD

	No. of Respondents	Adjusted Percentage
1	95	17.6
2	88	16.3
3	79	14.6
4	53	9.8
5	21	3.8
6	36	6.6
None	166	31.0
Don't know	2	0.3
	540	100.0

TABLE 9: IDEAL NUMBER OF CHILDREN PER COUPLE

No. of Children	No. of Respondents	Adjusted Percentage
1	1	0.2
2	49	7.6
3	105	16.4
4	173	27.0
5+	153	24.0
As many as possible	72	11.2
None	1	0.2
Don't know	86	13.4
	640	100.0

Further questioning revealed a high degree of consistency between respondents' ideal and desired number of children (see Table 10). Slightly more respondents (62) desired only two children, or 'as many as possible' (121), as compared with the findings in Table 9. The mean number of children desired was 4.3, fractionally more than the mean ideal number (4.1) of children per couple.

TABLE 10: DESIRED NUMBER OF CHILDREN

No. of Children	No. of Respondents	Adjusted Percentage
1	1	0.2
2	62	9.5
3	101	15.5
4	169	26.0
5+	171	26.2
As many as possible	121	18.6
None	1	0.2
Don't know	25	3.8
	658	100.0

A concept of balance in family composition was noted. 86.2% of the respondents preferred to have children of both sexes, two male and two female. The desire of couples to have both sons and daughters is likely to increase the desired family size, until the sex ratio is achieved. The desire to have one or more sons seems to particularly influence family size in Lesotho. An informal discussion with some respondents revealed that husbands are not willing to limit family size until the desired number of sons have been born. This is because the traditional patrilineal family structure in Lesotho emphasizes primogeniture, the exclusive rights of inheritance by the eldest son. When the daughter of a family marries the son of another family, she takes the surname of her new family, and is no longer a member of her original family. A family without a son means termination of the family line. Thus, it has been the custom of Basotho families to have many children, particularly many sons. If one or more daughters are born, the family still longs for a son.

In rural Lesotho, sons remain an asset to the family. As long as a son is able to work, he not only earns his own living, but supports the extended family as well. A daughter, on the other hand, usually works for a few years while at home, and then moves in with her husband's family. A family with several sons is able to provide greater support to its elderly members.

During informal discussions, many respondents revealed that they preferred to have two sons: if one were to die, the other would be able to carry on the family name and receive the inheritance. When respondents were asked if it is 'important to have a boy child?', 91.2% answered yes (see Table 11).

TABLE 11: IS IT IMPORTANT FOR YOU TO HAVE A BOY CHILD?

	No. of Respondents	Adjusted Percentage
Yes	590	91.2
No	6	1.0
Doesn't matter	51	7.8
	647	100.0

Why is important to have a son?

- To help the family economically (64%)
- To carry on the family name (23%)
- To obtain inheritance (6.3%)
- Part of our custom to have a son (4.3%)
- Because there are few soldiers (0.6%)
- Don't know (1.8%)

From the responses to the question, 'Why is it important to have a son?', as outlined above, we noted that the economic advantages of having a son were given much more weight than other factors. Traditionally, parents have tended to regard their children as economic units that can relieve the financial load borne by parents. These days, some parents -- mainly the better-educated -- are increasingly regarding their children as additional burdens on their limited resources. This has created a changing situation in which the desirable number of children is being evaluated less in terms of economics and more in terms of emotional gratification. However, our findings indicated that sons are still regarded by 64% of the sample as economic units, as reported above.

Traditionally, most parents held the belief that it was imperative to have a large number of children -- up to ten -- so that at least some children would survive childhood diseases. However, because of the introduction and dissemination of modern medical services, infant and maternal mortality rates have been reduced considerably. This has altered people's attitudes towards the number of children they feel they need or want to have.

Another factor influencing the respondents' determination of their desired number of children, which emerged during informal discussion, was the fact that the cost of living in present-day Lesotho is very high. As a result, parents claim that they cannot afford to educate their children and improve their standard of living.

We found a minority and contradictory view among the educated and uneducated, who acknowledged the high cost of living, but nonetheless held -- mainly because of their religious beliefs -- that a couple should have as many children as God would allow. They noted that God had advised the children of Israel to be fruitful and multiply throughout the earth; therefore, restricting or limited one's family was viewed as ungodly.

As reported at the beginning of this section, 58.3% of the respondents had four or fewer children, and 51.2% desired four or fewer children. Next we asked the respondents if 'there are any reasons why a couple today might want to have fewer than five children.'

17% said there were reasons, but didn't state them;
27.8% said because of socio-economic conditions in Lesotho;
40% said it was too expensive to feed, clothe, and educate too many children today -- this reason was expressed mainly by students, civil servants and other groups who had post-secondary education;
15% said there were no reasons.

In sum, the desire to have or not to have further children depends not only on the number of living children, but also on the sex composition of the children. Our findings on family and sex preferences support earlier findings by the World Fertility Survey of Lesotho (1977) which noted that willingness to stop childbearing among women was determined by the number of sons they had. All women with girls wished to have a boy next time. A large proportion (56%) of those with one boy/one girl wanted another boy. A strong preference for sons was evident among balanced families with two living children.

7. DECISION-MAKING IN FAMILY PLANNING

Literature on fertility tends to lay too much emphasis on the study of fertility per se, without paying adequate attention to decision-making mechanisms within the family.

It has been noted that decision-making is predicated on two levels:

1. the educational background of the couple; and
2. the cultural environment in which the couple lives (Studies in Family Planning, 1981).

Gille (1984) showed that couples with little or no education tend to relegate the final decision about family size to the husband. On the other hand, in families where members have secondary education and above, decision-making tends to rest with both partners, although the males may still have the final word.

Our study did not find a strong association between educational level and decision-making; however, education status was correlated with the decision-making process.

There is a general tendency among family planning administrators, population 'experts', and laymen to assume that the husband is the sole decision-making in African families. In order to determine the extent to which this assumption is true among the Basotho, five questions on decision-making were asked. The first queried male attitudes towards women's independence over family planning: do you think your wife should inform you if she uses a contraceptive device? The second question dealt with the respondents' objective opinions about decision-making in family planning. The subsequent questions were concerned with the respondents' subjective opinions on family planning.

In answer to the first question, 85% of all male respondents, irrespective of their socio-economic and religious affiliation, held that their spouse or partner should inform them before deciding to use a contraceptive method. However, 70% noted that in marriage, family planning should be discussed and a joint decision reached.

Marital decision-making about contraceptive use can be an emotionally-charged topic, and may result in covert use by women, or an emotionally unstable relationship between couples. Research done by Jose Van Kesteren (1983) in a family planning clinic in Mafeteng identified over 400 female respondents who were using family planning methods without prior consultation with their husbands or boyfriends. She further noted that there was a high rate of discontinuation of contraception among those females who had not obtained the consent of their husbands. On discovering that their wives were using family planning devices, husbands often angrily brought their wives to the clinic to have the prescription discontinued. They objected to the use of family planning methods, either because they were not informed, or because they feared that their wives or girlfriends were using contraception because they wanted to take lovers while their husbands or boyfriends were away in the mines.

Werner, et. al. (1983) has shown that women are usually the main initiators of family planning, but refrain from seeking contraception because they fear resentment from their husbands. Women, especially those in the lower socio-economic groups and rural areas, often report threats of abandonment by their husbands if they voice intentions of using birth control measures. However, women invariably initiate the discussion either in a hesitant or indirect fashion. Men, on the other hand, are usually under pressure from their peer groups not to allow their wives to use contraceptives. A man who 'obediently' gives in to his wife's request is viewed as 'soft' and not a 'real man'.

Our study found that family planning was more widely practiced by married respondents over the age of 30 years, than by unmarried men. Joint agreement on contraceptive methods was more often reached by respondents who were civil servants (45%) than by miners (20%).

8. CONTRACEPTION

Methods Used

82% of the male respondents had never used any contraceptive device, while 18% had. Of those who had never used contraceptives, 30% didn't know 'anything about contraceptives', while 23.4% said that 'it was not necessary'. When questioned further, 40% of the respondents said that women are the ones who get pregnant, and they should protect themselves, while 15% hadn't used contraceptives 'because it was againt God's will'.

Of the 18% who had used or were using contraceptive devices, 7.3% started during the past one to four years. When the respondents were asked if they liked using contraceptives, 38.8% said yes, and 33.4% said no. Of the methods currently used, 12% were using the condom. 18% of the user complained that it was unreliable, while 29% reported that it lacked sensitivity. The remainder of the sample (82%) did not report contraceptive use. It is likely that some respondents were using withdrawal, the rhythm method, or abstinence, but did not consider these methods to be contraception, and therefore did not report them.

Respondents using birth control measures were asked whether the elder (parents, grandparents, aunts, and uncles) in their families knew that they were using contraceptives, and if they did, would they approve? 83% said that their relatives didn't know that they were using contraceptives, but that if they did, they would disapprove.

Attitudes Towards Male Sterilization

One of our interests in the study was to find out how many of our respondents had heard about vasectomy. 18.4% had heard about it, while 81.6% hadn't. Those who had not heard about vasectomy were given a brief talk about vasectomy by the interviewers. After this explanation, the respondents were asked whether they thought vasectomy was a good idea. In response, 75.2% said it was a 'bad idea', 14.8% a 'good idea', and 10% 'didn't know'. These findings could have been influenced by the way in which the interviewers briefed the respondents; however, all interviewers were issued with a similar information sheet.

Despite widespread unpopularity, would an individual consider vasectomy if he didn't want any more children? In response to this question, 77.9% of the respondents said no, while 6.7% would definitely consider it, and 12.4% would possibly try it (see Table 12).

Those who said that vasectomy was a bad idea further stated that it was culturally unacceptable for a man to be sterilized, because such a person would be laughed at by other men in the village, and would be regarded as a 'sissy'. Further, he would expose himself to the danger of fathering children which he did not produce, but who were born because of his wife's infidelity.

TABLE 12: WOULD YOU CONSIDER VASECTOMY IF YOU DESIRED NO MORE CHILDREN?

	Absolute Frequency	Adjusted Percentage
Yes definitely	43	6.7
Yes possibly	79	12.4
No	498	77.9
Don't know	19	3.0
	639	100.0

Research done in Zaire has reported that vasectomised men did not exceed 50 in the whole country (Draper Fund Report, 1983). Most of those who were vasectomized asked that the procedure be kept secret, because they feared that their society would consider them less than men, 'diminished' in some way.

9. CONTRACEPTION, PRE-MARITAL SEX, AND PROMISCUITY

Providing family planning services for young unmarried people is a sensitive issue in most countries, especially in traditional societies like Lesotho. Within the last five years, there has been a steady increase in the number of unmarried young women who visit family planning clinics and doctors, seeking advice and subsequently become contraceptive acceptors (LLPA Clinic Supervisor). This change in contraceptive behaviour is probably due to modernization/ westernization, and the development of educational facilities throughout the country. Education is now available to a larger section of the society. This has been complemented by the increasing independence of women. As women become independent wage earners, they are less willing to follow traditionally prescribed roles. They demand that men play an active role in domestic and child-rearing activities.

Despite changing attitudes towards contraception, pre-marital sexual behaviour is still frowned upon by the majority of Basotho. However, changing attitudes towards modern contraceptive practices have been reflected by the fact that 45.3% of the sample supported the provision of contraceptives to unmarried young people; 45.1% were against it, and 9.6% remained undecided.

Those who supported the provision of services to unmarried people cited three main reasons:

1. it would prevent unwanted pregnancies;
2. it would reduce the number of illegitimate children;
3. it would prevent young girls from bring disgrace to their families.

Further analysis revealed several variables implicated in these attitudes:

1. Married respondents (41.4%) did not support the idea of providing contraceptives to unmarried young people; however, unmarried respondents (53.2%) did).

2. Students (86%) and civil servants (66.7%) were more supportive than the unemployed (35.8%) and miners/ self-employed (33.8&).

3. Respondents from the rural mountain areas (36.2%) and foothills (44.9%) were less supportive of the provision of contraceptives to unmarried couples than those from the lowlands (48.9%) and urban centres (73.5%).

4. Those who had no education and didn't complete primary education (55%) felt that unmarried individuals should not be provided with contraceptives. Those who were secondary and university graduates (32%) were more supportive.

In most societies, there seems to be an underlying belief that the provision of family planning services for unmarried young people encourages pre-marital sex and promiscuity. To test this belief, we asked our respondents the following questions:

1. Do you think providing contraceptive services to unmarried young people would encourage pre-marital sexual activity?

2. Does the use of contraceptives encourage promiscuity?

3. Is it men or women who are more likely to be promiscuous, or is it both?

As outlined in Table 13, 66.4% of all respondents stated that the provision of family planning services to unmarried people would certainly encourage pre-marital sexual activity.

TABLE 13: WOULD CONTRACEPTIVES ENCOURAGE PRE-MARITAL SEX?

	No. of Respondents	Adjusted Percentage
Certainly will	432	66.4
Possibly will	83	12.7
It depends upon the individual	59	9.1
No	29	4.4
Don't know	48	7.4
	651	100.0

Married respondents over 25 years of age, Catholics, miners, and those living in the rural mountains, believed that the provision of family planning services would encourage pre-marital sexual activity. The married respondents, students, and civil servants living in the urban centre were more liberal, and noted that pre-marital sexual activity does not necessarily lead to promiscuity.

Negative attitudes were also held about the relationship between contraception and promiscuity. 67% of the respondents stated that contraception encouraged promiscuity, while 22% disagreed.

In response to the question: 'Is it men or women who are more likely to be promiscuous if they use contraceptives, or is it both?', 7% of the respondents replied that 'men were more likely', 29% considered 'women more likely', and 41.2% thought both. The remainder were uncertain. The Lesotho Distance Teaching Centre study reported similar findings: 'men more likely', 10%; 'women more likely', 32%; 'both', 58%.

10. AWARENESS OF BIRTH CONTROL METHODS

Respondents' awareness and knowledge of contraceptive methods varied according to age, marital status, occupational status, religious affiliation, and level of education. Respondents were asked if they had heard about the contraceptive pill, contraceptive injection, IUD, and foaming tablet. The responses to these questions are reported in Table 14.

TABLE 14: KNOWLEDGE OF CONTRACEPTIVE METHODS

	Response	Adjusted Percentage
Have you heard about the contraceptive pill?	Yes	58.0
	No	42.0
Have you heard about the contraceptive injection?	Yes	45.4
	No	54.6
Have you heard about the IUD (loop, coil)?	Yes	38.5
	No	61.5
Have you heard about foaming tablets?	Yes	31.0
	No	69.0

As the table above indicates, the pill is the most widely-known contraceptive method. Respondents who were aged 25-35 (38%), married (69%), Catholic (30.2%), with post-secondary education (42.7%), and from the rural lowlands (31.6%), were more knowledgeable about the contraceptive pill than respondents under 24 years and over 35 years, unmarried (28.5%), LEC (16%), with incomplete secondary and primary education (5.6%), unskilled (26.5%), and from the rural mountains (24.3%). The contraceptive injection, IUD and foaming tablets were less widely-known methods in all categories of respondents.

Attitudes Towards Methods

When asked what they thought of contraceptive methods in general, respondents gave varied responses: 19.4% did not like any of the methods, 1.8% wanted 'nothing to do with contraceptives', 22.4% knew nothing about them, and 30.5% felt that the methods were 'O.K. if they don't endanger life'.

As indicated earlier, the pill was the most widely-known method of contraception. Accurate knowledge of the pill's advantages and disadvantaged varied, but the pill was generally perceived as easy to take, effective, and popular. However, there was also a general awareness that the pill can have adverse effects, such as causing 'spotting', intermittent bleeding, skin discolouration, and obesity.

The contraceptive injection was the second most widely-known contraceptive among the respondents. The major advantages noted were:

1. that the injection is given every three months;
2. that the woman doesn't require very many check-ups; and
3. that it doesn't cause any physical discomfort for either partner.

Few respondents mentioned any of the health dangers and possible infertility associated with injectables.

The IUD was a less widely-known female contraceptive than the pill or the contraceptive injection. Its perceived advantages included practicality, reliability (i.e. it is usually in place), and the infrequent need for check-ups. The major disadvantages noted were:

1. that it will damage a women and cause infection (35%);
2. that pregnancies can develop outside the womb (12%);
3. that it causes discomfort (22%); and
4. that it can be felt during intercourse (i.e. the man cannot 'go in far enough' (31%).

Foaming tablets were the least-known and used method. Respondents believed that:

1. they are messy (21%);
2. they are unreliable (34%); and
3. they are unhealthy (15%).

As stated earlier, the majority of the respondents disliked using certain contraceptives (the condom and foaming tablets), either because they reduce sensitivity, or because they don't find it necessary to use them. Further questioning revealed that respondents don't find it necessary to use contraceptives because their wives or girlfriends are using contraceptives. To find out the extent of use by female partners and preferred methods, respondents were asked: 'Which method does your wife or girlfriend use?' 69.5% of the respondents said that their wives or girlfriends were not using any form of contraception; 10.5% did not know what method their wives or girlfriends were using. Of the methods noted as being used by female partners, the IUD was the most frequently reported method (8.4%), followed by the pill (4.5%).

TABLE 15: WHICH METHOD DOES YOUR WIFE OR GIRLFRIEND PREFER?

	No. of Respondents	Adjusted Percentage
Pill	25	4.5
Injection	13	2.4
IUD	46	8.4
Rhythm	5	1.0

(cont. next page)

TABLE 15: WHICH METHOD DOES YOUR WIFE OR GIRLFRIEND PREFER? (cont.)

	No. of Respondents	Adjusted Percentage
Foaming tablets	3	0.5
Other	18	3.2
None	383	69.5
Don't know	58	10.5
	551	100.0

Other questions were intended to determine the way in which respondents view the use of contraceptives by their wives or girlfriends. Do they approve of it? If so, which method do they prefer wives/girlfriends to use? In response to these questions, 40% of the respondents said that they would not like their wives/girlfriends to use any method, while 24% were undecided. 13% of the respondents preferred their spouses and girlfriends to use the IUD, rather than any other method. Foaming tablets were consistently not preferred, as noted in Tables 15 and 16.

TABLE 16: WHICH METHOD DO YOU PREFER YOUR WIFE OR GIRLFRIEND TO USE?

	No. of Respondents	Adjusted Percentage
Pill	67	11.1
Injection	46	7.0
IUD	79	13.1
Foaming tablets	3	0.5
Rhythm	4	1.0
Other	20	3.3
None	240	40.0
Don't know	143	24.0
	602	100.0

Reliability of Contraceptive Methods

Questions on reliability were phrased in the form: 'Can a woman become pregnant if . . . ?'. The results are presented in the following table.

TABLE 17: RELIABILITY OF CONTRACEPTIVE METHODS

	Response	Adjusted Percentage
Can a woman become pregnant if she is taking the pill?	Yes	17.5
	No	39.0
	Don't know	43.5
Can a woman become pregnant if she has recently had the contraceptive injection?	Yes	4.5
	No	40.8
	Don't know	54.7
Can a woman become pregnant if a man uses a condom during intercourse?	Yes	15.8
	No	41.1.
	Don't know	43.1

The majority of respondents were unsure about the reliability of the contraceptive methods in preventing pregnancy. This finding is probably related to the high percentage of respondents who had never heard about contraceptive methods (pill, IUD, foaming tablets and the contraceptive injection). See Table 14.

11. CHILD SPACING

One of the major benefits of contraception is that it enables a couple to 'enjoy life' before starting to raise a family. It also allows mothers to relax between childbirths. There are several factors, however, which might affect child spacing, particularly the husband's impatience to prove his wife's fertility and his own virility, and the number of children the couple would like to have.

As is often the case in many African countries, child spacing and family planning were practiced before people became exposed to the influences of Christian missionaries and 'modern' family planning methods. Traditionally, people depended on cultural norms to practice child spacing. Chiefs were responsible for setting an example for their

people. King Moshoeshoe I, for example, had a two-year period between the births of his children, even though he had many wives. Mothers were encouraged to have children at two to four year intervals. This would enable children to get enough breast milk and be weaned properly. The health of the mother was not of prime concern, but she benefitted as a result of this practice.

It was a stigma on a woman and her spouse to have a child every year -- she was said to be 'behaving like a sheep or a goat' (Ntate Damane). Women also had a code of conduct, which evolved over time, and which was adopted by the women's council. This council consisted mainly of elderly women, and such councils still exist today in traditional villages. The council did not judge people, but it did subject some women to questioning regarding their behaviour. They were reproached if they failed to follow customary practices. The council acted as an agent of social control, reinforcing traditional norms, values, and mores (Ntate Damane).

Men had similar non-formal councils, which consisted mainly of men who had been circumcised. Such men often worked and fought together. This bonding meant that men were expected to regulate their household in such a way that children were born at 'decent' intervals (Ntate Damane).

To determine the contemporary attitudes of male Basotho regarding child spacing, we asked respondents whether a woman should have another baby soon after she has had one, or whether she should wait for some time. Almost all of the respondents (95%) said that she should wait for some time.

TABLE 18: SHOULD A WOMAN HAVE A BABY AS SOON AS SHE CAN OR SHOULD SHE WAIT?

	No. of Respondents	Adjusted Percentage
Should wait	617	94.6
Should not wait	12	1.8
It depends on her health	4	0.6
Don't know	19	3.0
	652	100.0

We also asked about the ideal interval between births. Over 70% held that two to three years was the best interval. An analysis of Table 19 (below) indicated that 18.8% of the of the respondents were of the opinion that 0 - 12 months would be an adequate period of time between pregnancies. However, the majority of respondents (77.2%) preferred an interval of two or more years between births; the mean waiting period was one to two years. The LDTC study noted that 80% of the respondents thought that a woman should wait for two years between births.

TABLE 19: LENGTH OF TIME BETWEEN BIRTHS

	No. of Respondents	Adjusted Percentage
Shouldn't wait	2	0.3
6 - 11 months	16	2.5
1 year	104	16.0
2 years	285	44.0
3 years	184	28.4
4 years	15	2.3
5+ years	16	2.5
Don't know	25	4.0
	647	100.0

Our respondents were further asked about the advantages of spacing children. There was widespread agreement that there are many advantages to the child. Some of the advantages are outlined in Table 20.

Although we did not inquire directly about ways in which the mother benefits as a result of spacing children, approximately 40% of the respondents informally said that it 'gave the woman time to gain her strength and become strong'.

TABLE 20: ADVANTAGES TO CHILD IF MOTHER SPACES CHILDREN

	No. of Respondents	Adjusted Percentage
The child grows and is healthy and fit	253	40.0
It is properly breast fed and weaned	185	29.2
Gets more love and attention from parents	103	16.2
The parents are better able to clothe and feed the child	37	5.8
Never thought about it	5	0.8
Don't know	51	8.0
	634	100.0

Our next question inquired about the ways in which child spacing can be practised. We observed that respondents were almost equally divided in their opinions. 40.0% supported modern contraception and 40.2% abstinence. See Table 21 below. This finding would seem to indicate that male attitudes towards contraceptive use for the purpose of child spacing have changed. The LDTC study reported that only 7% and 20% of men and women respectively supported using contraceptives, while 50% men and 73% women supported abstinence. Here our study revealed a loosening of traditional attitudes towards modern contraception, with 40% of the respondents favouring the use of contraceptive for child spacing.

TABLE 21: METHODS OF PRACTISING CHILD SPACING

	No. of Respondents	Adjusted Percentage
Contraception	264	41.0
Abstinence	260	40.2
Natural way	4	0.6
Not interested in child spacing	2	0.3

(cont. next page)

TABLE 21: METHODS OF PRACTISING CHILD SPACING (cont.)

	No. of Respondents	Adjusted Percentage
Other	2	0.3
Don't know	114	17.6
	646	100.0

Despite the noted change in male attitudes to contraception relating to child spacing, there was a high degree of adherence to traditional practices in respect to the recommencement of sexual intercourse following childbirth. In Lesotho, it is customary for women to breast feed for one to two years, and sometimes longer. During the period of breast feeding, sexual intercourse is not supposed to take place. There is a traditional belief that sexual intercourse during this period causes the breast milk to go 'bad' and makes the baby sick, in many cases leading to death.

As noted in Table 22 below, 43.2% and 12.3% of the sample held that women should wait between one to two and three to four years respectively after childbirth, before resuming sexual intercourse.

TABLE 22: WAITING PERIOD AFTER CHILDBIRTH BEFORE RECOMMENCING SEXUAL INTERCOURSE

	No. of Respondents	Adjusted Percentage
0 - 3 months	108	16.6
4 - 7 months	75	11.5
8 - 11 months	13	2.0
12 - 24 months	281	43.2
25+ months	80	12.3
Don't know	94	14.4
	651	100.0

However, 30% of the sample, consisting mainly of the younger age group, said that 0 - 11 months was an adequate waiting period before commencing sexual intercourse. 16.4% of this group suggested a shorter period of 0 - 3 months.

12. SUMMARY

Before discussing the need for more educational programmes in family planning, it will be useful to summarize briefly the main findings of our study.

1.) More than half of the respondents (67%) had heard of family planning. The national radio station was the single most effective method of disseminating knowledge of family planning, although only 24% of the 67% who had heard of family planning first learned about it from this source.

2.) About half of the respondents (49%) had three children or less; 18% had one child, 16% had two children, and 15% had three children.

3.) However, 27% of the respondents felt that the ideal and desired number of children was four, ideally comprised of two boys and two girls. 91.2% noted that it is important to have a son for economic and inheritance purposes.

4.) 85.3% of the respondents said that family planning should be a joint decision made by both partners. While insisting on their right to be involved in family planning decisions, however, most respondents disapproved of female contraceptives.

5.) Although some church authorities -- mainly Catholic -- disapprove of artificial family planning methods, 65% of the respondents said that their religious belief had no impact on their attitude towards family planning and contraception. Most respondents said that family planning is good, but they were apprehensive about using contraceptives because of the stories they heard regarding side effects.

6.) 81% of the male respondents had never used any male contraceptives, mainly because it was 'never necessary' (47%), or because they 'did not know' about male contraceptives (30%).

7.) 81.6% of the respondents had never heard of vasectomy. After hearing a talk about vasectomy, 78% said that they would never be vasectomised, while 19% would possibly consider it.

8.) The majority of respondents (66%) linked the provision of contraceptives to unmarried young people to increased pre-marital sexual activity and promiscuity.

9.) Respondents' awareness, knowledge, and practice of family planning and contraceptive practices/methods varied according to age, marital status, occupational status, religion and level of education and geographical locality.

10.) Respondents aged 20 - 34, living in urban areas, married, civil servants/students, non-Catholics, and post-secondary graduates, were more knowledgeable about family planning and contraception. They also preferred smaller families, and were more liberal in their attitudes about providing contraception to unmarried young people.

11.) On average, 50% of respondents did not know about the various 'artifical/modern' contraceptive methods. Of four such methods, the pill was the most widely known (58%) and foaming tablets the least known (69%).

12.) Despite lack of knowledge and dislike for contraceptives, 31% of respondents felt that the methods were 'OK if they don't endanger life'.

13.) 40% of the respondents noted that the best method of child spacing and practising family planning was to use contraceptives.

14.) Most respondents (72%) held that there should be up to a 2 - 3 year interval between births.

15.) 43% felt that a couple should refrain from sexual intercourse for two years following child birth. However, 30% of respondents, consisting mainly of the younger age group of 19 - 24, said that 0 - 11 months was an adequate waiting period before recommencing sexual intercourse.

13. RECOMMENDATIONS

Family Planning

1.) The proportion of males who have heard of family planning (66%) is much higher than in the LDTC study (18%) of 1978. On average, however, 60% of males did not know about contraception (methods and use). This implies that LPPA's main educational effort should continue to be the provision of basic information on family planning and contraception.

2.) Our findings confirmed the importance of the local radio station as a major source through which family planning

is received. There is therefore a need for more educational programmes via this medium.

3.) Males rarely visit clinics or attend family planning pitsos. They view such services as being primarily intended for women. In order to reach males, it is necessary to make programmes more accessible to them.

4.) LPPA's fieldworkers are predominantly female, and are apt to encounter cultural and traditional taboos in their attempts to discuss family planning with males. LPPA should recruit more male fieldworkers and plan specific ways of reaching males. Initially, they should consider such 'captive audiences' as prisoners, juvenile delinquents (at the Training Centre), mine labour (at the recruitment centres), cadets, and army and police personnel.

5.) There is a need to develop a special project to inform males about male contraceptive methods, particularly the condom. This project could be linked to present LPPA and Ministry of Health (MOH) programmes on sexually-transmitted diseases.

6.) LPPA presently has a stock of audio-visual programmes which were originally designed for women, and which are inappropriate for men. Moreover, most video programmes are presented in English, without a Sesotho translation. Since English is a second language for most rural Basotho, most of the information transmitted via this medium is not understood by the listener(s). LPPA should develop Sesotho language audio-visual programmes, so that the family planning message reaches audiences with the maximum impact.

Family Size

7.) We observed a high degree of consistency between ideal and desired family size. Most respondents (26%) wanted and desired four children, two boys and two girls. This finding contrasts sharply with the LDTC study (1978) which noted that 35% of the sample wanted 1 - 5 children, and 58% wanted 'as many as God wishes'. Our findings, then, indicate that there has been a trend towards smaller families; this is especially so of the younger and better-educated respondents. However, the desire of husbands to have sons would appear to create a disjunction between desired and actual family size; the woman/spouse continues to become pregnant until one or more sons have been born. In this context, family planning programmes should not tell couples how many children they should have, but should highlight the advantages of having a small family, both for the parents and children. Couples can be shown that they can choose their family size by using contraceptives.

8.) In the present socio-legal climate in Lesotho, it may be difficult to persuade males that they should not relentlessly desire sons. However, they should be made aware that daughters can be, and are, as important as sons, and that a large family can be physical strain on wives.

Decision-Making in Family Planning

9.) Males firmly stated that family planning and contraceptive use should be a joint decision by both partners, and that women should not become contraceptive users without prior discussion with their husbands. However, we have noted that wives often become family planning acceptors (Van Kestern, 1983) without informing their husbands, primarily because they are afraid their husbands would disapprove. Husbands disapprove because:-

1. they suspect that their wives have taken lovers;
2. they are afraid of losing control over their wives; and
3. they are ignorant about contraceptive methods.

Since men agree that family planning should be a jointly-resolved issue within the family, even while disapproving of covert contraceptive use by their wives, there is a need for a family planning programme which highlights the importance of husbands and wives discussing sexually-related and family planning matters. In Lesotho, such topics are very rarely discussed between husbands and wives. This situation breeds suspicion and secrecy, and may lead to conflict; one partner decides to use contraception, and the other feels slighted, offended, and threatened by not being told.

10.) It would appear from Van Kestern's study (1983) that many women would like to initiate family planning discussion, but are afraid to do so because of their husbands' real or imagined hostility towards it. This is an important area of education for LPPA. There is a need to remove those barriers which inhibit communication and family planning acceptance.

Contraception

11.) Over half of the respondents did not know about contraceptive methods and how they work. I would hypothesize that one of the biggest obstacles to contraceptive use by both males and females is this ignorance of contraceptives. Unless males become more knowledgeable or aware of family planning, there is very little real value in continuing to promote family planning and obtaining new female acceptors who later discontinue after six to nine months. It is essential for LPPA to inform males about the various male and female contraceptives, their advantages and disadvantages, so that individuals can select and continue to use appropriate methods.

12.) There is real fear among respondents that contraception encourages people to be promiscuous. Furthermore, the respondents maintain that women tend to be more promiscuous than men. This perhaps partially explains why some husbands oppose their wives' use of contraception. Many husbands are absent in the mines for long periods, and therefore they see no reason why their wives should require contraceptives. A solution to this problem would be to encourage the use of condoms instead of female contraceptives.

Child Spacing

13.) There is no need to convince people of the importance of child spacing; they already believe and practise it. There is, however, a need to reinforce its use. In this context, the LPPA can promote a 'new' method of child spacing, that is, contraception instead of abstinence. The advantages of this 'new' method must be indicated to couples, so that they can make a choice about how to space their children.

14.) Promoting male contraception (the condom) might possibly dispel the customary belief that the male's sperm causes the breast milk to go bad, and the baby/young child to become ill.

15.) The LDTC study indicated that abstinence causes unhappiness to many couples. Many women in the survey reported that it was difficult for a man to abstain from intercourse while his wife was breastfeeding (i.e. for two years or more). LPPA could greatly assist couples to overcome this problem by encouraging the use of the condom, or by convincing them that breastfeeding is compatible with intercourse, provided they use effective contraception.

14. CONCLUSION

Family planning educational programmes frequently focus on women rather than men, couples or families, and therefore do not promote the development of favourable male attitudes towards family planning. A greater effort should be made to improve such family planning programmes, so that they can effectively reach both men and women, encourage joint decision-making about family planning, and increase male support for women using or wishing to use contraceptives.

The opposition of a partner or husband to family planning has affected contraceptive use in many countries. Studies in Bangladesh, Ghana, Korea, the Philippines and USA all document the importance of male support for family planning. The husband's support is a good predicator of future practice and continued use. Wives whose husbands do not give support have low continuation rates (Population Centre Foundation, 1979).

In addition to increasing male support for the practice of family planning in the family context, a further effort is also needed to reach male opinion leaders and decision-makers, who could promote family planning programmmes, at both national and local levels.

Projects aimed at promoting male involvement in family planning could include in their objectives:-

1. motivating male leaders;
2. reaching men in the organized sector;
3. promoting male family planning methods; and
4. reaching adolescents.

15. BIBLIOGRAPHY

Gille, H. Attitudes Towards Family Planning. Draper Fund Report No. 13, June 1984.

Hall, B.L. 'Participatory Research: An Approach for Change.' Convergence, 1975.

Kayembe, T.B. Traditional Structures Clash with New Imperatives. Draper Fund Report No. 12. Washington: Population Crisis Committee, 1983.

Kingdom of Lesotho, Central Bureau of Statistics. Lesotho Fertility Survey 1977. 2 vols. World Fertility Survey. Maseru: Central Bureau of Statistics, 1981.

Lesotho Distance Teaching Centre. Attitudes to Family Planning in Lesotho. Maseru: Lesotho Distance Teaching Centre, 1978.

Lesotho Distance Teaching Centre. Education for Family Planning in Lesotho: Evaluation of the Project. Maseru: Lesotho Distance Teaching Centre, 1980.

Motsone, C.H. Family Planning Attitudes in Urban Lesotho, 1983.

Munford, S.D. 'The Vasectomy Decision-Making Process'. Studies in Family Planning 14:3, March 1983.

Population Centre Foundation and the Research Utilization Project in Biomedicine. A Look at the Problems of Discontinuation: A State of the Art. Manila: Population Centre Foundation.

Stokes, B. Men and Family Planning. World Watch Paper No. 41. Washington: World Watch Institute, 1980.

Suyono, H.; Pict N.; et al. 'Family Planning Attitudes in Urban Indonesia, Part I.' Studies in Family Planning 12:12, December 1981.

Van Kesteren, J. Labour Migration, Family Planning and Fertility in Lesotho. Gromingen, 1983.

Way, P. Sexual Stereotypes, Feminism, and the Male Role in Family Planning. Male Role in Family Planning Conference Proceedings, June 1977.

Werner, L.H.; and Dow, T.E. 'Perceptions of Family Planning Among Rural Kenyan Women.' Studies in Family Planning 14:2, February 1983.

Winikoft, B. 'The Effects of Birth Spacing on Child and Maternal Health.' Studies in Family Planning 14:10, October 1980.

APPENDIX 1: INTERVIEW SCHEDULE

MALE ATTITUDES TO AND RESPONSIBILITIES IN FAMILY PLANNING IN LESOTHO

AGE	15 - 19	1
	20 - 24	2
	25 - 29	3
	30 - 34	4
	35 - 39	5
	40 - 49	6
	45 - 49	7
	50+	8
	Don't know	9
MARITAL STATUS	Unmarried	1
	Married	2
	Divorced/separated	3
	Widowed	4
EMPLOYMENT STATUS	Unemployed (job-seeking)	1
	Employed/self-employed	2
	Retired	3
	Student	4
OCCUPATIONAL STATUS	Surface worker	1
	Underground worker	2
	Office worker	3
	Other	4

FROM WHICH VILLAGE ARE YOU?

FROM WHICH DISTRICT ARE YOU?

WHAT RELIGION ARE YOU?	Catholic	1
	Anglican	2
	LEC	3
	Methodist	4
	SDA	5
	Baptist	6
	Other (specify)	7
	None	8

AT WHAT LEVEL OF EDUCATION DID YOU FINISH SCHOOL?	Primary only (incomplete)	1
	Primary (graduate)	2
	Secondary (incomplete)	3
	Secondary (graduate)	4
	Post-secondary or above	5
	Other (specify)	6
	None	7
WHAT'S YOUR TOTAL INCOME/ WAGE PER MONTH?	M100 or below	1
	M150 - 160	2
	M160 - 170	3
	M170 - 180	4
	M180 - 190	5
	M200 or above	6
	Not applicable	7
WITH WHOM ARE YOU LIVING?	Wife	1
	Children	2
	Mother	3
	Mother-in-law	4
	Father	5
	Father-in-law	6
	Grandparents	7
	Alone	8

Family Planning

HAVE YOU EVER HEARD ABOUT FAMILY PLANNING?	Yes	1
	No	2

If yes,

WHERE DID YOU FIRST HEAR ABOUT FAMILY PLANNING?

If not from parents,

DID YOUR PARENTS EVER TALK TO YOU ABOUT FAMILY PLANNING?	Yes	1
	No	2
	Don't know	3
	Can't remember	4
HAVE YOU HEARD A TALK ABOUT FAMILY PLANNING GIVEN BY A . . .	Nurse	1
	Doctor	2
	Family planning educator	3
	Minister of religion	4
	Other	5

HAVE YOU HEARD ABOUT FAMILY PLANNING WHILE ON CONTRACT LABOUR?	Yes	1
	No	2
	Not applicable	3

HAVE YOU HEARD ABOUT THE LESOTHO FAMILY PLANNING ASSOCIATION OR THE LESOTHO PLANNED PARENTHOOD ASSOCIATION?	Yes	1
	No	2

DOES YOUR MINISTER OF RELIGION APPROVE OF FAMILY PLANNING?	Yes	1
	No	2
	Don't know	3

If no,

WHY DOESN'T HE APPROVE? (Record actual response.)

_____

_____

_____

IF YOU WERE TO ATTEND A FAMILY PLANNING CLINIC, WHO DO YOU THINK WOULD BE THE MOST HELPFUL PERSON FOR YOU TO SEE?	Nurse	1
	Social worker	2
	Field educator	3
	Doctor	4
	Other	5
	Don't know	6

DO YOU KNOW IF THERE ARE ANY FAMILY PLANNING CLINICS IN THIS AREA? IF SO, WHERE ARE THEY LOCATED?

_____ _____ _____

_____

HOW MUCH DO YOU THINK YOU SHOULD PAY FOR THE FAMILY PLANNING SERVICE PER CLINIC VISIT?	Less than M2.00	1
	Between M2.00 and M5.00	2
	Over M5.00	3
	Free-of-charge	4
	It doesn't matter how much	5
	Don't know	6

HOW MUCH TIME WOULD YOU BE PREPARED TO SPEND VISITING A CLINIC?	More than one hour	1
	One hour	2
	Half an hour	3
	Fifteen minutes	4
	Less than fifteen minutes	5
	Don't know	6

HOW MANY CHILDREN DO YOU HAVE?

_____

HOW MANY LATE CHILDREN DO YOU HAVE?

_____

WHAT SEX WERE THEY?

_____

If more than one,

HOW MANY CHILDREN FROM THE FIRST WIFE?

_____

HOW MANY CHILDREN FROM THE SECOND WIFE?

_____

WHAT DO YOU THINK IS THE IDEAL NUMBER OF CHILDREN FOR A COUPLE TODAY?

_____

HOW MANY CHILDREN WOULD YOU LIKE TO HAVE?

_____

WOULD YOU LIKE YOUR CHILDREN TO BE . . .	All boys	1
	All girls	2
	Mixed	3
	Doesn't matter	4
	To have any	5

DID YOU AND YOUR WIFE/GIRLFRIEND JOINTLY AGREE ON WHAT FAMILY PLANNING METHOD TO USE?

Yes	1
No	2
Can't remember	3
Don't know	4
Not applicable	5

If no,

WHO DECIDED WHAT CONTRACEPTIVE METHOD YOUR WIFE/GIRLFRIEND SHOULD USE?

_____

Contraception

HAVE YOU YOURSELF EVER USED CONTRACEPTIVES OF ANY KIND? (Stress yourself and ever.)

Yes	1
No	2
Don't know	3

If no,

WHAT IS THE REASON FOR YOUR NEVER HAVING USED CONTRACEPTIVES?

_____

_____

_____

If yes,

ARE YOU USING THEM AT THE MOMENT?	Yes	1
	No	2

HOW LONG AGO DID YOU START USING CONTRACEPTIVES?

_____

DO YOU LIKE USING CONTRACEPTIVES?	Yes	1
	No	2

WHAT METHOD OF CONTRACEPTION ARE YOU USING AT THE MOMENT?	Condom	1
	Rhythm	2
	Rhythm and simple method	3
	Sterilization	4
	Other	5

WHAT FAMILY PLANNING METHODS DID YOU USE BEFORE USING THE CURRENT CONTRACEPTION? (Prompt.)

_____

_____

ARE YOU SATISFIED WITH THIS METHOD OF CONTRACEPTION?	Yes	1
	No	2

If no,

WHY?

_____

_____

_____

DO THE ELDERS IN YOUR FAMILY KNOW THAT YOU ARE USING CONTRACEPTIVES?	Yes	1
	No	2
	Don't know	3
	I am not using them	4

If yes,

DO THEY APPROVE?	Yes	1
	No	2

If no, or don't know,

WOULD THEY APPROVE IF THEY KNEW?	Yes	1
	No	2

WHAT IS YOUR MAIN SOURCE OF SUPPLY AT PRESENT?	FPA	1
	Government clinic	2
	Private doctor	3
	Chemist shop/druggist	4
	Other	5
	Don't know	6
HAVE YOU EVER BEEN TO A CLINIC TO HAVE CONTRACEPTIVE COUNSELLING?	Yes	1
	No	2

WHICH CLINIC DID YOU ATTEND?

DO YOU THINK THAT A FAMILY PLANNING CLINIC SHOULD PROVIDE CONTRACEPTIVE SERVICES FOR UNMARRIED YOUNG PEOPLE?

DO YOU THINK IT WOULD ENCOURAGE PRE-MARITAL SEXUAL ACTIVITIES?	Certainly will	1
	Possibly	2
	No	3
	Don't know	4

DOES THE USE OF CONTRACEPTION ENCOURAGE PROMISCUITY?

IS IT MEN OR WOMEN WHO ARE LIKELY TO BE PROMISCUOUS IF THEY USE CONTRACEPTIVES, OR IS IT BOTH?

DOES YOUR TRADITIONAL RELIGIOUS BELIEF (CHURCH) AFFECT YOUR ATTITUDE TOWARDS CONTRACEPTION?

HAVE YOU EVER HEARD ABOUT VASECTOMY?	Yes	1
	No	2

WHAT DO YOU THINK ABOUT VASECTOMY? IS IT A GOOD IDEA OR NOT?

_____

_____

WHAT ABOUT YOURSELF: IF YOU AND YOUR WIFE/WIVES DECIDED THAT YOU DID NOT WANT ANY MORE CHILDREN, WOULD YOU CONSIDER VASECTOMY?

	Yes definitely	1
	Yes possibly	2
	No	3
	Don't know	4

HAVE YOU HEARD ABOUT . . .	Contraceptive pills	1
	Contraceptive injection	2
	IUD (loop, coil)	3
	Foaming tablets	4

WHAT DO YOU THINK ABOUT THESE METHODS? (Prompt.)

_____

_____

_____

WHICH METHOD DOES YOUR WIFE OR GIRLFRIEND USE?

_____

WHICH METHOD WOULD YOU PREFER YOUR WIFE OR GIRLFRIEND TO USE?

_____

CAN A WOMAN BECOME PREGNANT WHILE SHE IS TAKING THE PILL?	Yes	1
	No	2
. . . IF SHE RECENTLY HAD THE CONTRACEPTIVE INJECTION?	Yes	1
	No	2
. . . IF THE MAN USES A CONDOM DURING INTERCOURSE?	Yes	1
	No	2

Child Spacing

HOW MANY CHILDREN WOULD YOU LIKE TO HAVE?

_____ _____

ARE THERE ANY REASONS WHY A COUPLE MIGHT WANT TO HAVE FEWER THAN FIVE CHILDREN?

_____

_____

_____ _____

AFTER A WOMAN HAS HAD A BABY, SHOULD BE HAVE ANOTHER AS SOON AS SHE CAN, OR SHOULD SHE WAIT FOR SOME TIME?

_____

HOW LONG SHOULD SHE WAIT?

_____

ARE THERE ANY ADVANTAGES TO THE CHILD IF THE MOTHER WAITS FOR SOME TIME BEFORE SHE HAS ANOTHER CHILD?

_____

_____

_____

HOW DO YOU THINK A COUPLE CAN PRACTICE CHILD SPACING?

_____

_____

HOW LONG SHOULD A WOMAN WAIT AFTER CHILD BIRTH BEFORE SHE HAS SEXUAL INTERCOURSE?

_____

CAN A WOMAN BECOME PREGNANT IF SHE HAS SEXUAL INTERCOURSE WHILE BREASTFEEDING?

_____

APPENDIX 2: RESUME OF LETTERS RECEIVED BY LPPA FROM MINERS IN SOUTH AFRICA FROM LATE 1983 TO DATE.

1. Complains that it is not right for women to be given contraceptives without the expressed consent of her husband.

2. LPPA should print and sell T-shirts with family planning message.

3. Request remittance of a booklet on the withdrawal method.

4. A newly-married man who wants to know about family planning.

5. Would like to know how to bring up his children well -- clothe, feed -- while still having sexual intercourse with his wife -- afraid of her becoming pregnant.

6. Requests a booklet on family planning.

7. Has a one-year baby, wife doesn't want to use contraceptives, doesn't know what to do, afraid of her becoming pregnant again.

8. Is unmarried, has many girlfriends he would like to 'sleep with', but is afraid he may have an unwanted baby -- seeks advice.

9. Has read a leaflet on family planning, but it only dealt with contraceptives -- says nothing about family planning. Would like to know what family planning is.

10. Has read a leaflet on contraceptives -- seeks further advice.

11. Seeks further information about the pill and condoms. Concerned about wives receiving information -- booklets/ leaflets -- on family planning, without the consent of husbands. Thinks that this practice would encourage promiscuity.

12. A school boy would like to use contraceptives, so that he doesn't get into trouble before completing his studies.

13. Seeks advice about family planning.

14. Would like more information about child spacing.

15. Has used a condom, but he and his girlfriend find it messy. What can they use apart from the pill and IUD?

16. Need explanation of contraceptives.

17. Two miners want to know if the use of contraceptives does not result in killing life. Also, whether sexual abstinence during breastfeeding is a Basotho custom.

26 letters were received, 19 seeking further advice about family planning, and six critical of family planning.